



# Progressive Leadership Academy

Not just an alternative.....but an **ADVANTAGE!**

## PLA Enrollment Cover Form

Date: \_\_\_\_\_ Student Name: \_\_\_\_\_ ID# \_\_\_\_\_

Completed Online Lottery Application: Y / N Confirmation# \_\_\_\_\_

Student/Parent Interviewed? Y / N Interview completed by: \_\_\_\_\_

Recruited by: \_\_\_\_\_ Start date: \_\_\_\_\_ Completed by: \_\_\_\_\_

### SOCIAL MEDIA ACCOUNT INFORMATION

Facebook \_\_\_\_\_ Instagram \_\_\_\_\_ Snap Chat \_\_\_\_\_

NOTES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### \*Registrar/Dean ONLY:

Transcript attached? Y / N Transcripts approved? Y / N Imm. Recs? Y / N

ACT/SAT Scores? Y / N FASFA Completed? Y / N

Registrar Signature: \_\_\_\_\_

Dean Signature: \_\_\_\_\_

#### \*YS3 Officer:

Is student a Foster Child? Y / N Is student a Ward of the State? Y / N  
(If so, there is programming available to assist you.)

#### \*Diverse Learner Section:

Is student a diverse learner? Y / N I.E.P Included? Y / N 504 Included? Y / N

Is approval needed by the Nurse? Y / N (If so, attach approval or have nurse sign)

Must have an original signature; an electronic signature is not acceptable.

**Youth Connection Charter School  
Chicago Public Schools  
School Enrollment Form**

**School Name** YCCS-Progressive Leadership Academy

<b>Student Information</b>  Student's siblings' names if currently enrolled in CPS:  <hr/> <hr/> <hr/>	<table border="1"> <tr> <td data-bbox="405 349 655 450"> <b>School Use Only:</b>            Prevent duplicate student records. Search in SIS for an existing Student ID <u>before</u> creating a new one.         </td> <td data-bbox="655 349 1516 719">           Student ID# _____             Legal Last Name _____ Legal First Name _____ Legal Middle Name _____ Generation (Jr., etc) _____             Legal Sex (F/M/X/N) _____ Birth date (mm/dd/yyyy) _____ Registration Grade Level (when first entering CPS) _____             Affirmed Gender* (F/M/N) _____ Affirmed First Name* _____ Affirmed Middle Name* _____            *Optional. For more information regarding affirmed gender and affirmed name, please visit: <a href="#">Supporting Gender Diversity Toolkit</a> </td> </tr> </table>	<b>School Use Only:</b> Prevent duplicate student records. Search in SIS for an existing Student ID <u>before</u> creating a new one.	Student ID# _____  Legal Last Name _____ Legal First Name _____ Legal Middle Name _____ Generation (Jr., etc) _____  Legal Sex (F/M/X/N) _____ Birth date (mm/dd/yyyy) _____ Registration Grade Level (when first entering CPS) _____  Affirmed Gender* (F/M/N) _____ Affirmed First Name* _____ Affirmed Middle Name* _____ *Optional. For more information regarding affirmed gender and affirmed name, please visit: <a href="#">Supporting Gender Diversity Toolkit</a>						
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<b>Personal Information</b>	<table border="1"> <tr> <td colspan="2">           Y / N            Birth Certificate on File _____ Birth Verification Type _____         </td> </tr> <tr> <td>           * Birth Country _____         </td> <td>           Birth State _____ Birth City _____         </td> </tr> <tr> <td colspan="2">           * Complete if student was <u>not</u> born in the United States (US) or one of its Territories:            Date of first enrollment in any US School: _____            Full Years completed school in US: _____         </td> </tr> <tr> <td colspan="2"> <b>School Use Only:</b> Note that "Date of first enrollment in any US School" becomes a required field in SIS if "Birth Country" is <u>not</u> the US or one of its Territories.         </td> </tr> </table>	Y / N Birth Certificate on File _____ Birth Verification Type _____		* Birth Country _____	Birth State _____ Birth City _____	* Complete if student was <u>not</u> born in the United States (US) or one of its Territories: Date of first enrollment in any US School: _____ Full Years completed school in US: _____		<b>School Use Only:</b> Note that "Date of first enrollment in any US School" becomes a required field in SIS if "Birth Country" is <u>not</u> the US or one of its Territories.	
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<b>Student Address/Phone</b>  Physical (Home) Address  Mailing Address (if different than Home)	<table border="1"> <tr> <td>           Street Number and Name _____ Apt. _____ City _____ State _____ Zip Code _____         </td> </tr> <tr> <td>           Street Number and Name _____ Apt. _____ City _____ State _____ Zip Code _____         </td> </tr> <tr> <td>           Home Phone Number _____ Email Address: _____         </td> </tr> </table>	Street Number and Name _____ Apt. _____ City _____ State _____ Zip Code _____	Street Number and Name _____ Apt. _____ City _____ State _____ Zip Code _____	Home Phone Number _____ Email Address: _____					
Street Number and Name _____ Apt. _____ City _____ State _____ Zip Code _____									
Street Number and Name _____ Apt. _____ City _____ State _____ Zip Code _____									
Home Phone Number _____ Email Address: _____									
<b>Demographic, Home Language, Parent/Guardian Contacts, Emergency/Health Information</b>	Federal Ethnic and Race Categories: <i>(Enter information into SIS from the Race and Ethnicity Survey form)</i> Home Language Survey: <i>(Enter information into SIS from the Home Language Survey form)</i> Parent/Guardian Contacts: <i>(Enter information into SIS from the Request for Emergency and Health Information form)</i> Emergency/Health Information: <i>(Enter information into SIS from the Request for Emergency and Health Information form)</i>								
<b>Enrollment</b>  <b>Enrollment Status Codes:</b> 01 – No Former School 02 – Chicago Public School (to incl. Charter/Contract) 03 – Chicago Private School 04 – IL Public Schl, not Chicago 05 – IL Private Schl, not Chicago 06 – US Public Schl, not Illinois 07 – US Private Schl, not Illinois 08 – Not in USA	<table border="1"> <tr> <td>           *School Transferring From <i>(if not a Chicago Public, Charter or Contract School)</i> _____ City and State _____         </td> </tr> <tr> <td>           *Is the student in good standing? <u>Y / N</u>  <i>(Instructions to school: for out-of-state public school or any private school students, a certification of "good standing" should be received from the Parent/Guardian. Refer to CPS Policy 10-0623-PO1 for more information.)</i> </td> </tr> <tr> <td>           Last Chicago Public, Charter, or Contract School Attended _____         </td> </tr> <tr> <td>           Is the student receiving any type of Special Education services? <u>Y / N</u>  <i>(Instructions to school: if yes, please notify the Case Manager.)</i> </td> </tr> <tr> <td>           Student Enrolled by _____  <i>(Print Name and Relationship)</i> </td> </tr> <tr> <td>           Signature of Parent/Guardian _____ Date of Enrollment _____         </td> </tr> <tr> <td> <b>School Use Only:</b>            Enrollment Status Code <i>(insert a # from the left)</i> _____ Grade Level _____ Homeroom/Division # <b>553</b> </td> </tr> </table>	*School Transferring From <i>(if not a Chicago Public, Charter or Contract School)</i> _____ City and State _____	*Is the student in good standing? <u>Y / N</u> <i>(Instructions to school: for out-of-state public school or any private school students, a certification of "good standing" should be received from the Parent/Guardian. Refer to CPS Policy 10-0623-PO1 for more information.)</i>	Last Chicago Public, Charter, or Contract School Attended _____	Is the student receiving any type of Special Education services? <u>Y / N</u> <i>(Instructions to school: if yes, please notify the Case Manager.)</i>	Student Enrolled by _____ <i>(Print Name and Relationship)</i>	Signature of Parent/Guardian _____ Date of Enrollment _____	<b>School Use Only:</b> Enrollment Status Code <i>(insert a # from the left)</i> _____ Grade Level _____ Homeroom/Division # <b>553</b>	
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## STUDENT ENROLLMENT INFORMATION

### Personal Information

Student Name \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_  
Home Address \_\_\_\_\_ City/Zip Code \_\_\_\_\_  
Alternate Address \_\_\_\_\_ City/Zip Code \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ Alternate Phone(\_\_\_\_) \_\_\_\_\_  
Are you currently employed? YES or NO IF Yes, Where? \_\_\_\_\_

### Parent/Guardian Information

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_  
Father's Phone \_\_\_\_\_ Mother's Phone \_\_\_\_\_  
Address \_\_\_\_\_ City & Zip \_\_\_\_\_  
Father's Email Address \_\_\_\_\_  
Mother's Email Address \_\_\_\_\_

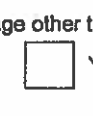
### Medical Information

Do you have a doctor or Medical Center you frequent? Yes or No  
Name of Doctor \_\_\_\_\_ Medical Center or Hospital \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ May we contact in an emergency? Yes or No

### Emergency Contact Information

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Complete this Home Language Survey at the student's initial enrollment in a Chicago Public School.  
This form must be kept in the student's folder.

School: _____ Room: ____ School ID #: _____ Network: _____	
Student Name: _____ Student IS #: _____	
<b><u>English</u></b>	
<p>1. Is a language other than English spoken in your home?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes _____ (Language) <p>2. Does the student speak a language other than English?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes _____ (Language)	<div style="border: 1px solid black; padding: 5px;"> <b>IMPACT REGISTRATION PROCESS</b>          (For Office use only)  <ul style="list-style-type: none"> <li>• The Non-English language identified on either question is the Home Language.</li> <li>• If two different non-English languages are identified, enter the language identified in question 2 as the Home Language.</li> <li>• Enter ENGLISH as a Home Language ONLY when both questions are answered no.</li> </ul> </div>
If the answer to either question is yes, the law requires the school to assess your child's English language proficiency.	
<b>Romanian</b>  1. În familia dvs. se vorbește și altă limbă decât engleza?? <input type="checkbox"/> Nu <input type="checkbox"/> Da _____ (limba)	<b>Yoruba</b>  1. Njẹ e n sọ èdè miran yatọ si Èdè-Gẹ̀gẹ́si ninu idile yin bí? <input type="checkbox"/> Bẹ̀kọ́ <input type="checkbox"/> Bẹ̀ni _____ (Èdè)
2. Studentul vorbește și altă limbă decât engleza? <input type="checkbox"/> Nu <input type="checkbox"/> Da _____ (limba)	2. Še akékòṣí náà n sọ èdè miran yatọ sí èdè-Gẹ̀gẹ́si bí? <input type="checkbox"/> Bẹ̀kọ́ <input type="checkbox"/> Bẹ̀ni _____ (Èdè)
Dacă ați răspuns afirmativ la oricare dintre întrebări, prin lege, Instituția de învățământ trebuie să evalueze cunoștințele de limbă engleză ale copilului dvs.	
<b>Assyrian</b>   .ܐܡܝܪܝܬܢ ܕܥܠܟܘܢ ܚܳܰܦܩܶܗܽܘܢ ܫܺܝܒܳܰܬܿܬܵܐ ܨܳܰܠܴܛܳܬܼܐ ܕܥܠܟܘܢ ܙܺܝܕܳܰܬܿܬܵܐ ? (ܨܳܰܠܴܛܳܬܼܐ) ----- ܐ̈ܺܝ൬ ܐ̈ܺܝ൬	<b>Gujarati</b>  1. શું આપના ઘરમાં અંગ્રેજી સિવાયની ભાષા અન્ય કોઈ ભાષા બોલવામાં આવે છે? <input type="checkbox"/> ના <input type="checkbox"/> હા _____ (ભાષા)
.ܕܢܳܠܱܬܻܐ ܨܳܰܠܴܛܳܬܼܐ ܨܳܰܠܴܛܳܬܼܐ ܕܥܠܟܘܢ ܙܺܝܕܳܰܬܿܬܵܐ ܨܳܰܠܴܛܳܬܼܐ ? (ܨܳܰܠܴܛܳܬܼܐ) ----- ܐ̈ܺܝ൬ ܐ̈ܺܝ൬	2. શું વિદ્યાર્થીઓ અંગ્રેજી સિવાયની કોઈ ભાષા બોલે છે? <input type="checkbox"/> ના <input type="checkbox"/> હા _____ (ભાષા)
જો બન્નેમાંથી કોઈ એક પ્રશ્નો જવાબ પણ હા માં હોય તો, કાયદો શાળા પાસે તમારા બાળકના અંગ્રેજી ભાષાના કૌશલ્ય માટે આકારણી કરાવવા માગે છે.	
<b>Tagalog</b>  1. May iba pa bang lengguwahe bukod sa Ingles na ginagamit sa iyong tahanan? <input type="checkbox"/> Hindi <input type="checkbox"/> Oo _____(Lengguwahe)	<b>Korean</b>  1. 가정에서 사용하는 언어 중에서 영어를 제외한 다른 언어가 있습니까? 아니오 예 _____(언어)
2. May ginagamit ba na ibang lengguwahe ang mag-aaral bukod sa Ingles? <input type="checkbox"/> Hindi <input type="checkbox"/> Oo _____(Lengguwahe)	2. 학생이 영어 이외의 다른 언어를 구사합니까? 아니오 예 _____(언어)
Ayon sa batas, kung "Oo" ang sagot sa parehong tanong, kailangan suriin ng paaralan ang kakayahan at kaalaman ng mag-aaral sa wikang Ingles.	
상기의 질문 중 하나라도 "예"로 응답하신 경우에는, 관련 법에 따라 학교는 귀 자녀의 영어 구사 능력 개발을 지원해야 합니다.	

Notes:

- If the parent/guardian does not speak English and the school does not have staff who speaks the parent/guardian's language, identify the language spoken by the parent/guardian through any assistance available in the school.
- If exact name of the language cannot be determined, enter "Other" as a temporary entry. If you entered "Other," the exact language must be determined within two weeks after enrollment.
- If the language spoken by the parent is not reflected in this HLS, please visit the OLCE Forms page on the Knowledge Center at [bit.ly/OLCEforms](http://bit.ly/OLCEforms) and click on Home Language Survey in Additional Languages.



## Progressive Leadership Academy High School Early Release Authorization Form

Student  
Name \_\_\_\_\_

(First Name)

(Middle Name)

(Last Name)

Other Relation

Relationship \_\_\_\_\_

Name \_\_\_\_\_

Contact Address \_\_\_\_\_

Home Phone \_\_\_\_\_

Other Phone \_\_\_\_\_

Other Relation

Relationship \_\_\_\_\_

Name \_\_\_\_\_

Contact Address \_\_\_\_\_

Home Phone \_\_\_\_\_

Other Phone \_\_\_\_\_

Other Relation

Relationship \_\_\_\_\_

Name \_\_\_\_\_

Contact Address \_\_\_\_\_

Home Phone \_\_\_\_\_

Other Phone \_\_\_\_\_

I consent for PLA High School to release my child to the relatives mentioned above due in case of an emergency or early dismissals due to my incapability.

\_\_\_\_\_  
Parent Name

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date



## **PLA Handbook Student Signature Acknowledgement Page**

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This page is to acknowledge that I, \_\_\_\_\_, will follow  
(Student Name)

all rules and policies listed in the PLA handbook. I further understand that any violation may result in the loss of my device and/or technology privileges as well as other disciplinary action. The PLA-YCCS High School Student Handbook includes the Student Code of Conduct and The Parents Right to Know Letter. This handbook will provide information of the school's processes and procedures, which will assist in the culture and climate of PLA. All students and parents are expected to be in compliance with all rules and policies.

\_\_\_\_\_  
**Print Student Name**

\_\_\_\_\_  
**Student Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Parent Name**

\_\_\_\_\_  
**Parent Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Date**





ENGLISH

## **Race and Ethnicity Survey**

Student's Name:  
Gender:  
Birth Date:

School Name:  
School ID:

**INSTRUCTIONS:** Please answer the questions below. Both questions must be answered. Part A asks about the student's ethnicity and Part B asks about the student's race. If you decline to respond to either question, the school district is required to provide the missing information by observer identification.

**Part A.** Is this student Hispanic/Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)  
Choose only one.

- ☐ No, not Hispanic/Latino
- ☐ Yes, Hispanic/Latino

*The question above is about ethnicity, not race. No matter which answer you selected, continue and respond to the question below by marking one or more boxes to indicate what you consider this student's race to be.*

**Part B.** What is the student's race? Choose one or more.

- ☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.)
- ☐ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
- ☐ **Black or African American** (A person having origins in any of the black racial groups of Africa.)
- ☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
- ☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

## DOCUMENTATION

- Gather accurate information about the reaction, including who assisted in the medical intervention and who witnessed the event.
- Save food eaten before the reaction, place in a plastic zipper bag (e.g., Ziploc bag) and freeze for analysis.
- If food was provided by school cafeteria, review food labels with head cook.
- Follow-up:
  - Review facts about the reaction with the student and parents and provide the facts to those who witnessed the reaction or are involved with the student, on a need-to-know basis. Explanations will be age-appropriate.
  - Amend the Emergency Action Plan (EAP), Individual Health Care Plan (IHCP) and/or 504 Plan as needed.
  - Specify any changes to prevent another reaction.

## TRAINED STAFF MEMBERS

Name: \_\_\_\_\_

Room: \_\_\_\_\_

Name: \_\_\_\_\_

Room: \_\_\_\_\_

Name: \_\_\_\_\_

Room: \_\_\_\_\_

## LOCATION OF MEDICATION

- ☐ Student to carry
- ☐ Health Office/Designated Area for Medication
- ☐ Other: \_\_\_\_\_

## ADDITIONAL RESOURCES

### American Academy of Allergy, Asthma and Immunology (AAAAI)

414-272-6071

<http://www.aaaai.org>

[http://www.aaaai.org/patients/resources/fact\\_sheets/food\\_allergy.pdf](http://www.aaaai.org/patients/resources/fact_sheets/food_allergy.pdf)

[http://www.aaaai.org/members/allied\\_health/tool\\_kit/ppt/](http://www.aaaai.org/members/allied_health/tool_kit/ppt/)

### Children's Memorial Hospital

773-KIDS-DOC

<http://www.childrensmemorial.org>

### Food Allergy Initiative (FAI)

212-207-1974

<http://www.faiusa.org>

### Food Allergy and Anaphylaxis Network (FAAN)

800-929-4040

<http://www.foodallergy.org>

This document is based on input from medical professionals including Physicians, APNs, RNs and certified school nurses. It is meant to be useful for anyone with any level of training in dealing with a food allergy reaction.



# State of Illinois Certificate of Child Health Examination

<b>Student's Name</b>				<b>Birth Date</b>	<b>Sex</b>	<b>Race/Ethnicity</b>	<b>School /Grade Level/ID#</b>	
Last First Middle				Month/Day/Year				
Address Street City Zip Code				Parent/Guardian Telephone # Home Work				
<b>IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <u>every</u> dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.</b>								
<b>REQUIRED Vaccine / Dose</b>	<b>DOSE 1</b>		<b>DOSE 2</b>		<b>DOSE 3</b>		<b>DOSE 4</b>	
	MO	DA	YR	MO	DA	YR	MO	DA
<b>DTP or DTaP</b>								
<b>Tdap; Td or Pediatric DT</b> (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	
<b>Polio</b> (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV	
<b>Hib</b> Haemophilus influenza type b								
<b>Pneumococcal Conjugate</b>								
<b>Hepatitis B</b>								
<b>MMR</b> Measles Mumps Rubella							<b>Comments:</b>	
<b>Varicella</b> (Chickenpox)								
<b>Meningococcal conjugate (MCV4)</b>								
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose</b>								
<b>Hepatitis A</b>								
<b>HPV</b>								
<b>Influenza</b>								
<b>Other: Specify Immunization Administered/Dates</b>								
<b>Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.</b> If adding dates to the above immunization history section, put your initials by date(s) and sign here.								
<b>Signature</b>				<b>Title</b>		<b>Date</b>		
<b>Signature</b>				<b>Title</b>		<b>Date</b>		
<b>ALTERNATIVE PROOF OF IMMUNITY</b>								
<b>1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.</b> <b>*MEASLES (Rubeola)</b> MO DA YR <b>**MUMPS</b> MO DA YR <b>HEPATITIS B</b> MO DA YR <b>VARICELLA</b> MO DA YR								
<b>2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.</b> Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease. <b>Date of Disease</b> <b>Signature</b> <b>Title</b>								
<b>3. Laboratory Evidence of Immunity (check one)</b> <input type="checkbox"/> Measles* <input type="checkbox"/> Mumps** <input type="checkbox"/> Rubella <input type="checkbox"/> Varicella <b>Attach copy of lab result.</b> *All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence. **All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.								
<b>Completion of Alternatives 1 or 3 MUST be accompanied by Labs &amp; Physician Signature:</b> _____ Physician Statements of Immunity MUST be submitted to IDPH for review.								

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.

Last First Middle			Birth Date Month/Day/ Year		Sex	School	Grade Level/ ID
<b>HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER</b>							
<b>ALLERGIES</b> (Food, drug, insect, other)		Yes No	List:		<b>MEDICATION</b> (Prescribed or taken on a regular basis.)		Yes No
Diagnosis of asthma?		Yes	No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)		Yes No
Child wakes during night coughing?		Yes	No		Hospitalizations?		Yes No
Birth defects?		Yes	No		When? What for?		
Developmental delay?		Yes	No		Surgery? (List all.)		Yes No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.		Yes	No		When? What for?		
Diabetes?		Yes	No		Serious injury or illness?		Yes No
Head injury/Concussion/Passed out?		Yes	No		TB skin test positive (past/present)?		Yes* No
Seizures? What are they like?		Yes	No		TB disease (past or present)?		Yes* No
Heart problem/Shortness of breath?		Yes	No		Tobacco use (type, frequency)?		Yes No
Heart murmur/High blood pressure?		Yes	No		Alcohol/Drug use?		Yes No
Dizziness or chest pain with exercise?		Yes	No		Family history of sudden death before age 50? (Cause?)		Yes No
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____				Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other			
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Information may be shared with appropriate personnel for health and educational purposes.			
Ear/Hearing problems?		Yes	No		<b>Parent/Guardian</b>		
Bone/Joint problem/injury/scoliosis?		Yes	No		<b>Signature</b>		
					<b>Date</b>		
<b>PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA</b>							
HEAD CIRCUMFERENCE if < 2-3 years old		HEIGHT		WEIGHT		BMI	BMI PERCENTILE
							B/P
<b>DIABETES SCREENING</b> (NOT REQUIRED FOR DAY CARE) <b>BMI&gt;85% age/sex</b> Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>							
<b>LEAD RISK QUESTIONNAIRE:</b> Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)							
<b>Questionnaire Administered?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> <b>Result</b>							
<b>TB SKIN OR BLOOD TEST</b> Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. <a href="http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm">http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm</a> .							
<b>No test needed</b> <input type="checkbox"/> <b>Test performed</b> <input type="checkbox"/> <b>Skin Test:</b> <b>Date Read</b> / / <b>Result:</b> Positive <input type="checkbox"/> Negative <input type="checkbox"/> <b>mm</b> _____ <b>Blood Test:</b> <b>Date Reported</b> / / <b>Result:</b> Positive <input type="checkbox"/> Negative <input type="checkbox"/> <b>Value</b> _____							
<b>LAB TESTS</b> (Recommended)		Date	Results			Date	Results
Hemoglobin or Hematocrit					Sickle Cell (when indicated)		
Urinalysis					Developmental Screening Tool		
<b>SYSTEM REVIEW</b>	Normal	Comments/Follow-up/Needs			Normal	Comments/Follow-up/Needs	
<b>Skin</b>				<b>Endocrine</b>			
<b>Ears</b>		Screening Result:		<b>Gastrointestinal</b>			
<b>Eyes</b>		Screening Result:		<b>Genito-Urinary</b>		LMP	
<b>Nose</b>				<b>Neurological</b>			
<b>Throat</b>				<b>Musculoskeletal</b>			
<b>Mouth/Dental</b>				<b>Spinal Exam</b>			
<b>Cardiovascular/HTN</b>				<b>Nutritional status</b>			
<b>Respiratory</b>		<input type="checkbox"/> Diagnosis of Asthma		<b>Mental Health</b>			
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist) <input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)				<b>Other</b>			
<b>NEEDS/MODIFICATIONS</b> required in the school setting				<b>DIETARY</b> Needs/Restrictions			
<b>SPECIAL INSTRUCTIONS/DEVICES</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup							
<b>MENTAL HEALTH/OTHER</b> Is there anything else the school should know about this student? If you would like to discuss this student's health with school or school health personnel, check title: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal							
<b>EMERGENCY ACTION</b> needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)? <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> If yes, please describe.							
On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.) <b>PHYSICAL EDUCATION</b> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Modified</b> <input type="checkbox"/> <b>INTERSCHOLASTIC SPORTS</b> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Modified</b> <input type="checkbox"/>							
Print Name		(MD,DO, APN, PA)		Signature		Date	
Address				Phone			



# Student Medical Information 2021 – 2022



**This form must be updated and returned to school each school year.**

*please print or type:*

Please let your school know about your child's health and health care. This is a good way to keep your child safe. The information is **CONFIDENTIAL** and will be shared only with CPS staff who need to know (Nurse, Principal, Designee, or Clerk).

STUDENT LAST NAME		FIRST NAME		MIDDLE NAME
GENDER	STUDENT DATE OF BIRTH		SCHOOL NAME	
STUDENT ID #	GRADE		ROOM #	

## 1. PLEASE INDICATE YOUR CHILD'S HEALTH STATUS BELOW.

☐ My child has no known health conditions.

**My Child has a known condition(s). Please check all that apply:**

☐ Allergies (food or other)

List Allergies

☐ Asthma

Year Diagnosed \_\_\_\_\_

☐ Seizures/Epilepsy

Year Diagnosed \_\_\_\_\_

☐ Diabetes (please select one) ☐ Type 1 ☐ Type 2 ☐ Other

Year Diagnosed \_\_\_\_\_

☐ Sickle Cell Disease

Year Diagnosed \_\_\_\_\_

☐ Other \_\_\_\_\_ Year Diagnosed \_\_\_\_\_

## 2. MY CHILD HAS A PRIMARY DOCTOR. ☐ YES ☐ NO

If yes, please provide the healthcare provider's name and phone number.

Name \_\_\_\_\_ Phone number \_\_\_\_\_

☐ I give permission for my child's school nurse or designee to talk to the doctor about my child's health.

## 3. MY CHILD IS COVERED BY HEALTH INSURANCE. ☐ YES ☐ NO

**If your child needs health insurance call  
Healthy CPS 773-553-KIDS (5437).**

This Form is **NOT** the same as a "Plan of Care" (detailed medical care instructions to keep your child safe). If your child has a health condition that may require action at school, please provide school with documentation from your physician and schedule an appointment with your school nurse. Complete a "Medical Plan of Care Form" at: [www.cps.edu/oshw](http://www.cps.edu/oshw) (or get it from the school nurse), and return it to school. **If your child has a health condition, please schedule an appointment with the school nurse.**

**Please return the form to the school nurse. If the student has a health condition, parents must schedule a meeting with the school nurse.**

Parent/Guardian Name \_\_\_\_\_ Date \_\_\_\_\_ Phone Number \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Email \_\_\_\_\_

**Nurses Use Only** Reviewed by (Initials) \_\_\_\_\_ Date \_\_\_\_\_ Revised April 25, 2019  
*Must have an original signature; an electronic signature is not acceptable*



# School Messaging Consent Form



Dear Parent/Guardian/Student:

If age 18 or older, Your school and the district will periodically want to send information regarding school or district events, updates or initiatives. We will utilize the phone messaging system to remind you about these events, updates, and initiatives; including report card distribution, field trips, community events, parent-teacher conferences, announcements, COVID-19 information and screenings, and more. To ensure you receive periodic school or district related notifications and reminders, your consent is needed below.

In the event of an emergency, whether or not consent is on file, you will be informed by all contact information provided. Emergency calls include weather closures, health risks, threats, unexcused absences, and other situations affecting the health or safety of students and faculty. Emergency calls will be sent to all the phone numbers, including cellular numbers listed on the student's record. Please make sure these numbers are updated with the school.

Please fill out and return this form to ensure you receive informational calls and texts.

**By signing this form, you are authorizing Chicago Public Schools to use an automated system to periodically deliver automated informational calls or text messages to the phone number(s) provided below. If you change your phone number or no longer wish to receive automated calls and texts, you agree to inform Chicago Public Schools immediately. By signing below, you agree that this consent will remain valid and you will continue to receive automated phone calls and text messages unless or until you revoke your consent. Standard messaging rates and data may apply.**

- ☐ I CONSENT as outlined in the above section.
- ☐ I DO NOT CONSENT as outlined in the above section.

*please print or type:*

Student's Name

Name of Parent/Guardian/Student if age 18 or older

School

Date

Signature of Parent/Guardian/Student if age 18 or older

Student ID #

Phone Number 1 for Messages

Phone Number 2 for Messages

E-mail Address

*Must have an original signature; an electronic signature is not acceptable*



# CPS Family Income Information Form 2021-2022



The purpose of this form is for CPS to obtain information about families' income to determine school funding. CPS and your school may receive additional funding based on the number of low-income families enrolled. Please complete this form and return it to the school's main office.

Parents— Please return form to school by **October 29, 2021**

Schools— Please enter into ODA by **November 18, 2021**.

please print or type

SCHOOL NAME

DOES YOUR FAMILY HAVE INTERNET SERVICES AT HOME? ☐ YES ☐ NO

**PART 1: Household Information—** List all members of your household living with you.

\*Foster Children (legal responsibility of welfare agency or court)

**PART 2: SNAP/TANF number of any member of your household (go to part 6)**

FOSTER CHILD?	CPS STUDENT?	ALL HOUSEHOLD MEMBER NAMES			DATE OF BIRTH	DHS SNAP OR TANF CASE NUMBER (LAST 9 DIGITS)							
		Last	First	M.I.									
<input type="checkbox"/>	<input type="checkbox"/>												
<input type="checkbox"/>	<input type="checkbox"/>												
<input type="checkbox"/>	<input type="checkbox"/>												
<input type="checkbox"/>	<input type="checkbox"/>												
<input type="checkbox"/>	<input type="checkbox"/>												
<input type="checkbox"/>	<input type="checkbox"/>												

**PART 3: Homeless, Migrant, Runaway Child, or child enrolled in Head Start**

- ☐ HOMELESS  
☐ MIGRANT  
☐ RUNAWAY  
☐ HEAD START

Homeless, Migrant, Runaway or Head Start Liaison Signature

Date

**PART 4: List Household Members With Income (SKIP THIS if you answered any of parts 2 or 3)**

Enter the amount of income and how often it is received for each household member.

Frequency: Weekly, Every 2 Weeks, Twice Monthly, Monthly, Annually

OTHER INCOME can be but not limited to Welfare, Child Support, Retirement, Social Security, Worker's Comp and Unemployment.

HOUSEHOLD MEMBER NAMES WITH INCOME			GROSS INCOME (before deductions)	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Annually	OTHER INCOME	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Annually
First	Last	M.I.												
			\$						\$					
			\$						\$					
			\$						\$					
			\$						\$					
			\$						\$					

**PART 5: Opt in for information about other benefits.**

- ☐ YES! I am interested in applying for a waiver of instructional fees.  
☐ YES! I am interested in applying for the Supplemental Nutrition Assistance Program (SNAP) and/or the Medicaid Program. Or call 773-553-5437

Signature

**PART 6**

**Signature:** I certify that all above information is true and all income is reported. I understand that information gathered from this form will be used to calculate Federal funding and screen CPS students for eligibility for other benefits and that school officials may verify (check) the information as being accurate; and that if I purposely give false information, I may be prosecuted.

Signature of adult household member

Parent / Guardian First Name

Parent / Guardian Last Name

Address

Zip Code

Date

Must have an original signature; an electronic signature is not acceptable.



# CPS Family Income Information Form 2021-2022



## PART 7: Children's Racial and Ethnic Identities (Optional)

### MARK ONE ETHNIC IDENTITY:

- ☐ Hispanic / Latino  
☐ Not Hispanic / Latino

### MARK ONE OR MORE RACIAL IDENTITIES:

- ☐ Asian ☐ Black / African American ☐ Native Hawaiian / Other Pacific Islander  
☐ White ☐ American Indian / Alaska Native

## Instructions For Completing Family Income Information Form

### IF YOUR HOUSEHOLD RECEIVES BENEFITS FROM SNAP/TANF, FOLLOW THESE INSTRUCTIONS:

**Part 1:** List all of the household members and date of birth (for students). (Attach another application if necessary.)

**Part 2:** List the DHS case number (SNAP or TANF) of any household member that corresponds with their name in Part 1. Do not use your Medicare card number.

**Skip to Part 5:** If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign.

**Part 6:** Sign the Form.

**Part 7:** Check the appropriate box to indicate your racial and ethnic identities.

### IF YOU ARE APPLYING FOR A HOMELESS, MIGRANT, RUNAWAY, OR HEAD START CHILD, FOLLOW THESE INSTRUCTIONS:

**Part 1:** List all of the household members and date of birth (for students).

**Skip to Part 3:** Check the appropriate box; obtain date and signature of Homeless, Migrant, or Runaway Liaison/Coordinator.

**Skip to Part 5:** If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign.

**Part 7:** Check the appropriate box to indicate your racial and ethnic identities.

### IF YOU ARE APPLYING FOR A FOSTER CHILD, FOLLOW THESE INSTRUCTIONS:

**If all children in the household are foster children:**

**Part 1:** List Students name, date of birth and check the box for "Foster Child" to the left of your foster child's name.

**Skip to Part 5:** If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign.

**Part 6:** Sign the Form.

### If some children in the household are foster children:

**Part 1:** List Students name, date of birth and check the box for "Foster Child" to the left of your foster child's name.

**Skip to Part 4:** Follow the instructions under ALL OTHER HOUSEHOLDS INSTRUCTIONS (Part 4) below.

**Part 5:** If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign.

**Part 6:** Sign the Form.

**Part 7:** Check the appropriate box to indicate your racial and ethnic identities.

### ALL OTHER HOUSEHOLDS, FOLLOW THESE INSTRUCTIONS:

**Part 1:** List all of the household members and date of birth (for students).

**Skip to Part 4:** Follow these instructions to report total household income:

#### Column 1: Name

List the first and last name of each person in your household who receives income, related or not (such as grandparents, other relatives, or friends. Attach another sheet of paper if necessary.).

#### Columns 2 & 3: Gross Income Amounts and Frequency

The Gross Income is the amount earned before taxes and other deductions. It should be noted on pay stubs. This is not the same as take-home pay. List the amount each person receives from these sources. Round to the nearest dollar. All other sources of income should also be noted on this application. Next to each amount fill in the circle that indicates how often the person receives their stated income (weekly, every other week, twice a month, monthly, or annually). If you do not wish to disclose your income, please note "decline to answer" in this section. Be aware that if you are low-income, failure to share household income information could reduce the funds your school may otherwise receive.

**Part 5:** If you are interested in sharing application information with Medicaid or SNAP agencies, check the box and sign.

**Part 6:** Sign the Form.

**Part 7:** Check the appropriate box to indicate your racial and ethnic identities.

## SCHOOL USE ONLY

Initial Determination: ☐ ELIGIBLE (Free or Reduced) ☐ INELIGIBLE (Denied, N/A or ?)

CONFIRMATION (Only for those applications selected for verification)

Signature of Confirming Official (Required)

Date



# Directory and Recruiter Opt-Out Information Sheet

August 2021 | Department of Policy and Procedures



**This Information Sheet for Students and Parents provides instructions on how you can use the “Directory and Recruiter Information Opt-Out Form” to prevent the release of your child’s student directory information. An Opt-Out Form is enclosed for your convenience.**

The Family Educational Rights and Privacy Act (FERPA), Illinois School Student Records (ISSRA), and Chicago Board of Education Policy 706.3 *Parent and Student Rights of Access to and Confidentiality of Student Records* require that Chicago Public Schools (CPS) obtain your written consent before disclosing personally identifiable information from your child’s education records, with certain exceptions. **The Chicago Public Schools may disclose “directory information” without written consent, unless you have advised the District that you do not want the information shared by using the form attached.** This form is to be turned in at time of enrollment.

## Who will have access to this information?

CPS may share directory information with third parties (such as city agencies or educational service providers) who have an educational interest in the information and request it. All requests from external parties related to research are reviewed by the CPS School Quality Measurement & Research or the CPS Office of College and Career Success to ensure the request is in the interest of students.

## What is directory information?

Directory information is information that is generally not considered harmful or an invasion of privacy if released. CPS has designated the following as directory information: student’s name; home address; home telephone number.

## How do I complete the CPS Directory Information Opt-Out Program Process?

A parent/guardian or student age 18 or older **must complete this form and return it to the school clerk annually at time of enrollment/registration.** If you have more than one child attending CPS, you must submit a separate request for each child. The Opt-Out Form requires a student identification number. **Please make sure you record the 8-digit ID number on the form accurately.**

## For parents/guardians of JUNIORS and SENIORS ONLY:

By law, if military recruiters request contact information (name, address, phone number) for 11th- or 12th-grade students, CPS is required to provide that information unless you choose to block it. Colleges and universities also may request student information. Using the Chicago Public Schools Opt-Out form, you may block the release of your contact information to military recruiters, or to colleges and universities, or to both.

Having your name placed on the Opt-Out list does not in any way limit your ability to request your school to send a transcript or any other material on your behalf to a college or university, a military recruiter, or others, upon request.

## Questions or Concerns?

If you have questions about CPS policy related to the release of student information to third parties, recruiters, or universities please contact [policy@cps.edu](mailto:policy@cps.edu).



# Directory and Recruiter Information Opt-Out Form

August 2021 | Department of Policy and Procedures



Dear Student, Parent or Guardian:

You have the right to inspect and copy your student's records, challenge the contents of such records, and limit your consent to the designated records or designated portions of information within the records.

If you DO NOT want directory information disclosed, complete this form and return it to the school clerk at time of enrollment/registration. If you do not submit a completed Opt-Out Form, your child's directory information may be provided to recruiters and external parties by CPS upon their request. If you submit this form but do not check at least one box, your child's directory information may be provided to recruiters and external parties upon their request. If you have more than one child attending CPS, you must submit a separate request for each child.

*please print or type.*

Student Name

Student ID Number (8 digits): *This is required*

School

Date

☐ DO NOT disclose my child's directory information to any external party without my prior consent.

## FOR HIGH SCHOOL JUNIOR AND SENIOR STUDENTS ONLY

You may block the release of your contact information specific y to military recruiters, colleges and universities, or both by checking the boxes below.

☐ DO NOT disclose my child's directory information to military recruiters without my prior consent.

☐ DO NOT disclose my child's directory information to colleges and universities without my prior consent.

Relationship to Student : Select one

Name

Signature

☐

SELF

☐

PARENT GUARDIAN

*Must have an original signature; an electronic signature is not acceptable.*



## **Progressive Leadership Academy** **OPEN FIELD TRIP PERMISSION FORM**

I, Parent or Guardian of \_\_\_\_\_,  
give permission for my child to attend all school managed and supervised  
trips and outings during the school year as a student of Progressive  
Leadership Academy. I understand that this is an open permission form,  
which removes the necessity of signing permission forms per school  
outings. I further understand that I will still be informed in a timely matter  
of any times and/or dates my child is not on school grounds.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date



## School-Parent Compact

From the Parental Involvement: Title I, Part A Non-Regulatory Guidance (April 23, 2004)

\* \* \* \* \*

### SCHOOL-PARENT COMPACT

**The Progressive Leadership Academy** and the parents of the students participating in activities, services, and programs funded by Title I, Part A of the Elementary and Secondary Education Act (ESEA) (participating children), agree that this compact outlines how the parents, the entire school staff, and the students will share the responsibility for improved student academic achievement and the means by which the school and parents will build and develop a partnership that will help children achieve the State's high standards.

This school-parent compact is in effect during the 2021-22 school year.

### REQUIRED SCHOOL-PARENT COMPACT PROVISIONS

Provisions bolded in this section are required to be in the Title I, Part A school-parent compact.

#### School Responsibilities

#### **The Progressive Leadership Academy will:**

1. **Provide high-quality curriculum and instruction in a supportive and effective learning environment that enables the participating children to meet the State's student academic achievement standards as follows:**

Our mission is to reduce high school dropout rates, increase academic achievement and learning through competency-based instruction, and empower students by preparing them for the next stage in life.

2. **Hold parent-teacher conferences (at least annually in elementary schools) during which this compact will be discussed as it relates to the individual child's achievement.** Specifically, those conferences will be held:

The campus will have semester meetings with parents to pick up report cards and discuss student achievement. Additionally, staff will be responsible to have bi-monthly calls to parents when an issue has been identified with a particular student.

3. **Provide parents with frequent reports on their children's progress.** Specifically, the school will provide reports as follows:

*Progressive Leadership Academy will provide all reports pertaining to students via mail, e-mail, or phone conference as it takes place. Through Power school, **Progressive Leadership Academy** is able to provide real time data on attendance, homework completion, special assignments and behavior reports to parents. **Progressive Leadership Academy** will provide training so parents can learn how to access the information which is 24/7.*

4. **Provide parents reasonable access to staff.** Specifically, staff will be available for consultation with parents as follows:

Staff will be available for parent conferences when the need arises. Conferences will be scheduled to accommodate the parent's schedule when possible. Staff is available before school starts, during school hours and after school hours.

5. **Provide parents opportunities to volunteer and participate in their child's class and to observe classroom activities, as follows:**

#### **Parent Responsibilities**

**We, as parents, will support our children's learning in the following ways:**

**Describe the ways in which parents will support their children's learning, such as:**

- Monitoring attendance.
- Ensuring that homework is completed.
- Monitoring amount of television children watch.
- Volunteering in child's classroom.
- Participating, as appropriate, in decisions relating to my child's education.
- Promoting positive use of my child's extracurricular time.
- Staying informed about my child's education and communicating with the school by promptly reading all notices from the school or the school district either received by my child or by mail and responding, as appropriate.
- Serving, to the extent possible, on policy advisory groups, such as being the Title I, Part A parent representative on the school's School Improvement Team, the Title I Policy Advisory Committee, the District-wide Policy Advisory Council, the State's Committee of Practitioners, the School Support Team or other school advisory or policy groups.

#### **Student Responsibilities**

**We, as students, will share the responsibility to improve our academic achievement and achieve the state's high standards. Specifically, we will:**

**Describe the ways in which students will support their academic achievement, such as:**

- Do my homework every day and ask for help when I need it.
- Read at least 30 minutes every day outside of school time.
- Give my parents or the adult who is responsible for my welfare all notices and information received by me from my school every day.
- Work on Aventa courses in my spare time at home or a library.
- Service Learning Hours/Senior Seminar
- Attend after-school programs that support academic progress, which includes tutoring.

\_\_\_\_\_  
School

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student

\_\_\_\_\_  
Date

# ILLINOIS FOOD ALLERGY EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION

Child's  
Photograph

NAME: \_\_\_\_\_ D.O.B: \_\_\_\_/\_\_\_\_/\_\_\_\_

TEACHER: \_\_\_\_\_ GRADE: \_\_\_\_\_

ALLERGY TO: \_\_\_\_\_

Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

Weight: \_\_\_\_\_ lbs

## ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:

LUNG: Short of breath, wheeze, repetitive cough  
HEART: Pale, blue, faint, weak pulse, dizzy, confused  
THROAT: Tight, hoarse, trouble breathing/swallowing  
MOUTH: Obstructive swelling (tongue)  
SKIN: Many hives over body

Or Combination of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling  
GUT: Vomiting, crampy pain

## INJECT EPINEPHRINE IMMEDIATELY

- Call 911
- Begin monitoring (see below)
- Additional medications:
- Antihistamine
- Inhaler (bronchodilator) if asthma

\*Inhalers/bronchodilators and antihistamines are not to be depended upon to treat a severe reaction (anaphylaxis) → Use Epinephrine.\*

\*\*When in doubt, use epinephrine. Symptoms can rapidly become more severe.\*\*

## MILD SYMPTOMS ONLY

Mouth: Itchy mouth  
Skin: A few hives around mouth/face, mild itch  
Gut: Mild nausea/discomfort

## GIVE ANTIHISTAMINE

- Stay with child, alert health care professionals and parent.

**IF SYMPTOMS PROGRESS (see above), INJECT EPINEPHRINE**

- ☐ If checked, give epinephrine for ANY symptoms if the allergen was likely eaten.  
☐ If checked, give epinephrine before symptoms if the allergen was definitely eaten.

## MEDICATIONS/DOSES

EPINEPHRINE (BRAND AND DOSE): \_\_\_\_\_

ANTIHISTAMINE (BRAND AND DOSE): \_\_\_\_\_

Other (e.g., inhaler-bronchodilator if asthma): \_\_\_\_\_

**MONITORING: Stay with the child. Tell rescue squad epinephrine was given. A second dose of epinephrine can be given a few minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised. Treat child even if parents cannot be reached.**

☐ Student may self-carry epinephrine

☐ Student may self-administer epinephrine

**CONTACTS: Call 911 Rescue squad: (\_\_\_\_) \_\_\_\_\_**

Parent/Guardian: \_\_\_\_\_ Ph: (\_\_\_\_) \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Ph: (\_\_\_\_) \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Ph: (\_\_\_\_) \_\_\_\_\_

Licensed Healthcare Provider Signature: \_\_\_\_\_ (Required) Phone: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I understand that the Local Governmental and Governmental Employees Tort Immunity Act protects staff members from liability arising from actions consistent with this plan. I also hereby authorize the school district staff members to disclose my child's protected health information to chaperones and other non-employee volunteers at the school or at school events and field trips to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child and for the implementation of this plan.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# ILLINOIS VOTER REGISTRATION APPLICATION

Suggested, August 2008

## FOR ILLINOIS RESIDENTS ONLY

### TO VOTE YOU MUST:

- Be a United States citizen
- Be at least 18 years old
- Live in your election precinct at least 30 days
- Not be convicted and in jail
- Not claim the right to vote anywhere else

### TO VOTE IN THE NEXT ELECTION:

- **Mail or deliver this application to your County Clerk or Board of Election Commissioners** no later than 28 days before the next election. ([click here for County Clerk/Election Board listings](#)) or go to [www.elections.il.gov](http://www.elections.il.gov)

### IMPORTANT INFORMATION:

- If you do not have a driver's license, State Identification Card or social security number, and this form is submitted by mail, and you have never registered to vote in the jurisdiction you are now registering in, then you must send, with this application, either (i) a copy of a current and valid photo identification, or (ii) a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows the name and address of the voter. If you do not provide the information required above, then you will be required to provide election officials with either (i) or (ii) described above the first time you vote at a voting place or by absentee ballot.
- If you change your name you must re-register.
- If you register at a public service agency, any information regarding the agency that assisted you will remain confidential as will any decision not to register.
- If you do not receive a Notice within 2 weeks of mailing or delivering this application, call your County Clerk or Board of Election Commissioners.

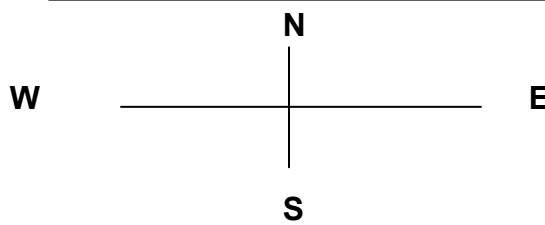
### TO COMPLETE THIS FORM:

SBE R-19

- Box 1-If you do not have a middle name, leave blank.
- Box 3-If mailing address is same as Box 2, write "same".
- Box 4-If you have never registered before, leave blank. If you do not remember your former address; provide as much information as possible.
- Box 5-If you have not changed your name, leave blank.
- Box 9-If you have an Illinois Driver's License or Secretary of State ID, check the first box and fill in the number. If you do not have a Driver's License or SOS ID, check the second box and fill in the last four digits of your Social Security Number. If you do not have a SSN, check the third box and send a copy of the appropriate document (as described in the "Important Information" section) along with this form.
- 10-Read, date and personally sign your name or make your mark in the box.

### IF YOU HAVE NO STREET ADDRESS,

below describe your home: list the name of subdivision; cross streets; roads; landmarks; mileage and/or neighbors' names.



If you have questions about completing this form, please call the State Board of Elections at (217)782-4141 or (312)814-6440 (or [webmaster@elections.il.gov](mailto:webmaster@elections.il.gov)).

TYPE OR PRINT CLEARLY IN BLACK OR BLUE INK

<b>Are you a citizen of the United States of America?</b> (check one) <b>yes</b> <input type="checkbox"/> <b>no</b> <input type="checkbox"/> <b>Will you be 18 years of age on or before election day?</b> (check one) <b>yes</b> <input type="checkbox"/> <b>no</b> <input type="checkbox"/> If you checked "no" in response to either of these questions, then do not complete this form.				<b>Office Use</b>	
You can use this form to: (Check One) <input type="checkbox"/> apply to register to vote in Illinois <input type="checkbox"/> change your address <input type="checkbox"/> change your name					
1. Last Name	First Name	Middle Name or Initial	Suffix (Circle One) Jr. Sr. II III IV		
2. Address where you live (House No., Street Name, Apt. No.)		City/Village/Town	Zip Code	County	Township
3. Mailing address (P.O. Box)		City/Village/Town, State		Zip Code	
4. Former Registration Address: (include City and State and Zip Code)			Former County	5. Former Name: (if changed)	
6. Date of Birth: MM/DD/YY	8. Home telephone number including area code (optional)		9. ID number – check the applicable box and provide the appropriate number		
7. Sex (circle one) M F	( ) -		<input type="checkbox"/> IL Driver's License or, if none, Sec. of State ID or <input type="checkbox"/> Last 4 digits of Social Security Number <input type="checkbox"/> I have none of the above-listed identification numbers.		

10. Voter Affidavit – Read all statements and sign within the box to the right.

#### I swear or affirm that

- I am a citizen of the United States;
- I will be at least 18 years old on or before the next election;
- I will have lived in the State of Illinois and in my election precinct at least 30 days as of the date of the next election;
- The information I have provided is true to the best of my knowledge under penalty of perjury. If I have provided false information, then I may be fined, imprisoned, or if I am not a U.S. citizen, deported from or refused entry into the United States.

This is my signature or mark in the space below.

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

11. If you cannot sign your name, ask the person who helped you fill in this form to print their name, address and telephone number.

Name of person assisting.

Full Address

Telephone No.

[illegible]

DATE	EXPLAIN	CLERK	DATE	EXPLAIN	CLERK

[illegible]